Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ C IL6000863 B. WING 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET **BETHALTO CARE CENTER** BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 Initial Comments S 000 Original Complaint Investigation 1945312/IL114137 1945317/IL114143 S9999 Final Observations S9999 Statement of Licensure Violations 300.110g) 300.510e) 300.810a) 300.1210b) 300.1220b)5) 300.2020 300.3300d)y) Section 300.110 General Requirements The licensee shall give 90 days notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than ten percent of the residents. Such notice shall be given to the Department, to any residents who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The licensee shall offer to assist the Attachment A resident in securing an alternative placement and shall advise the resident on available alternatives. **Statement of Licensure Violations** Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and Illinois Department of Public Health

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

M3XP11

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6000863 B. WING 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET BETHALTO CARE CENTER BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility as provided under the Act. (Section 3-423 of the Act) Section 300.510 Administrator The licensee and the administrator shall e) be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 300.810 General a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: Participating in planning and 5) budgeting for nursing services, including purchasing necessary equipment and supplies.

**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET BETHALTO CARE CENTER BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 2 S9999 Section 300.2020 Dietary Staff in Addition to Director of Food Services There shall be sufficient number of food service personnel employed and on duty to meet the dietary needs of all persons eating meals in the facility. Their working hours shall be scheduled to meet the total dietary needs of the residents. All dietary employees' time schedules and work assignments shall be posted in the kitchen. Dietary duties and job procedures shall be available in the dietary department for employees' knowledge and use. Section 300.3300 Transfer or Discharge d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (i) of this Section and by a minimum written notice of 21 days Any owner of a facility licensed under the y) Act shall give 90 days notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than 10% of the residents. Such notice shall be given to the Department, to any resident who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The facility shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives. Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including

those related to transfer or discharge of residents. The Department may place a

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED C IL6000863 B. WING 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET **BETHALTO CARE CENTER** BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 relocation team in the facility as provided under subsection (u) of this Section. (Section 3-423 of the Act) These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to provide written notification prior to impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and resident representatives. The facility failed to have a plan for the transfer and adequate relocation of the residents. The facility administrator failed to develop and implement a facility closure plan despite knowledge that facility closure was imminent due to persistent financial difficulties. The facility failed to provide notice of discharge at least 30 days before discharge. Residents and families were notified verbally on 7/22/2019 that the facility was closing and that the residents would need to be out of the building in three days. Residents were not given the required 60-day notice of closure. The facility's lack of actions related to impending financial concerns led to an inability to meet payroll. Upon abruptly learning that payroll would not be met, approximately one half of the staff walked off the job. Staffing levels were in jeopardy with no back up plan in place prior to the announcement that payroll would not be met. Cash reserves were stated as \$2000. The facility had been cash on delivery status for extended period for food and medical supplies. Food supplies estimated as 3-day supply. Food vendor

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET BETHALTO CARE CENTER BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 was Cash on Delivery. Facility staff reported that no medical supplier had been available for two weeks and that Pharmacy was threatening to be discontinued later the same week that V4 (Care Plan Coordinator) notified the Department of the facility's inability to meet payroll. The Administrator had no plan in place for orderly/safe relocation of the 43 residents. Residents and families rushed to find another place to reside due to poor planning and actions of the Administrator. Findings include: On 7/22/2019 at 2 pm V9 (Surveyor) stated that V4 (Care Plan Coordinator/CPC) called the Illinois Department of Public Health regional office at 8:40 am on Monday 7/22/2019. V4(CPC) told V9 that "this call is urgent." V4 (CPC) explained that V1 (Administrator) was very ill and had been under a lot of stress. V4 (CPC) attributed this stress to "the money issues--not getting paid by the State." V4 continued that V1 (Administrator) was out with "heart issues" and V4 did not know when the Administrator would be back. V4 stated that the facility was not "going to make payroll" that day (7/22/2019). V9 (Surveyor) informed V4 (CPC) that V4 would need to speak with V10 (Regional Supervisor). V4 (CPC) asked that V10 "call back as soon as possible because it was an emergency." V10 (Regional Supervisor) called the facility at 8:45 am on 7/22/2109 and spoke with V4 (CPC) and V5 (Bookkeeper). V4 stated again that the facility was unable to meet payroll on 7/22/2019 and that she wanted "guidance on closing the facility." V4 stated that the facility had \$2000 left with "savings used up and no line of credit." V5 (Bookkeeper) confirmed the absence of a line of

PRINTED: 09/06/2019

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED C IL6000863 B. WING 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **815 SOUTH PRAIRIE STREET** BETHALTO CARE CENTER BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 5 S9999 credit. V4 stated again that V1 (Administrator) was very ill and not in the facility at the time but was "aware of the situation." V4 (CPC) explained that food vendors were only accepting cash on delivery and that the facility had no medical vendors. V4 asked guidance on what to tell facility employees about not meeting payroll, fearing that staff would leave when given that news. V4 stated that families and residents were not aware of the facility's financial stress or the imminent plan for closure. V4 (CPC) continued stating "Thursday evening (July 18, 2019) after IDPH left (annual recertification survey exited on 7/18/2019) V1 (Administrator) and I sat here and discussed things and that Monday I would call Public Health. I thought that Public Health would help and lead us through the process. In the building we have a weeks' worth of food. Vendors are here. V1 (Administrator) told the kitchen to order it. The orders are cash on delivery so if it is not paid, it won't be left." V4 (CPC) verified on 7/22/2019 at 9:30 am that notices had not been sent to Illinois Department of Public Health, the Long-Term Care State Ombudsman or the residents regarding any planned closure of the facility. Illinois Department of Public Health surveyors arrived onsite at facility on 7/22/2019 at 1 pm. V1

stay. Illinois Department of Public Health

(Administrator) was onsite at this time. V1 stated at 1:20 pm on 7/22/2019 that the facility "did not meet the requirement for expedited Medicaid payment." V1 (Administrator) stated that she had "used up every bit of my reserve." V1 continued that she believed 50% of her staff would stay to care for the 43 residents but that three days would probably be the most any of the staff would

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **815 SOUTH PRAIRIE STREET BETHALTO CARE CENTER** BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 6 S9999 Interview with V7 (Director of Nursing) at 1:20 pm on 7/22/2019 confirmed that after the morning meeting ½ of the staff stayed and ½ "walked." Those leaving include all housekeeping staff and one LPN (Licensed Practical Nurse) who stayed until the end of her shift and stated she would not be back. Dietary staff stayed until end of shift but did not come back the next day. V4 (CPC) stated on 7/22/2019 at 1:20 pm "Thursday evening (July 18, 2019) after IDPH left (annual recertification survey exited on 7/18/2019) V1(Administrator) and I sat here and discussed things and that Monday I would call Public Health. I thought that Public Health would help and lead us through the process. In the building we have a weeks' worth of food. Vendors are here. V1told the kitchen to order it. The orders are cash on delivery so if it is not paid, it won't be left." V4 (CPC) stated at 1:30 pm on 7/22/2019 that "the staff was told at morning meeting that we would not make payroll. I thought at this time we would be transferring residents out. I tried to convince people to stay. I told them when I get money, I will pay them. Staff that was not here have not been notified." When questioned about current staffing levels in the building, V4 (CPC) stated on 7/22/2019 at 2 pm that 43 residents remained in the building. R32 was identified as "actively dying." According to V4 there were three nurses in the building; one registered nurse, one licensed practical nurse, and the Director of Nurses (RN) along with Social Services Designee, one housekeeper, two kitchen personnel, bookkeeper, maintenance director, Owner/Administrator and herself, the Care Plan Coordinator.

Illinois Department of Public Health

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING			(X3) DATE SURVEY COMPLETED	
		IL6000863			C 07/24/2019		
						24/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  845 SOUTH PRAIDLE STREET							
BETHALTO CARE CENTER  815 SOUTH PRAIRIE STREET  BETHALTO, IL 62010							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
S9999	99 Continued From page 7		S9999				
	food on hand in the of milk (which staff the next day), 10 po pounds roast beef, dogs, three dozen egallons of peas, car cereal, flour, sugar, Service Designee/C supply would last at	2019 surveyor confirmed that facility consisted of 10 gallons indicated would be gone by bunds of hamburger, 10 1 box cod fish filets, 30 hot eggs, 10 loaves of bread, three rots, and green beans, dry and oatmeal. V8 (Social book) indicated that the food bout three days. At the time of endor was onsite with facility d.					
	pm V1 (Administrate was unable to meet had delayed payroll closely coincide with payments were mad V1 stated if the facil closing. V1 blamed of Medicaid funding over 1 million dollars people." The Admin notice to her resider be providing them was not sure the come to work if they continued to take isslack of payments, black of payments, black of payments, black of payroll of the of the month was fur residents. During the distinguish which Staresponsible for funding Department was residents.						

**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET **BETHALTO CARE CENTER** BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY)** S9999 Continued From page 8 S9999 recorded, stating that she "wished it would be recorded and played for the media so that people would know who was at fault." When asked about providing notice to the residents. ombudsman, and the Department, V1 (Administrator) became annoyed at the reminder, stating "everyone keeps asking me about this notice-what is it-30 day or 60 days?" Staffing provided by the V7 (Director of Nursing) for second shift on 7/22/2019 included one LPN working 2:30 pm to 11 pm, one LPN working 2pm to 8 pm, and the Director of Nurses and three certified nursing assistants. Third shift staffing include one LPN coming in at 8 pm and staying until 7 am. with two certified nursing assistants working 11 pm to 7:30 am. Staffing for day shift on 7/23/2019 included an RN working 6:30 am until 3 pm, one LPN working 6:30 am until 8 pm with two certified nursing assistants and one more "possibly." V7 (DON) stated "We have not contacted staff that was not here today to tell them no payroll. I think we have enough staff to care for residents." CMS-672 indicates that the facility had five residents receiving respiratory treatments, four residents receiving injections, fourteen on mechanical soft diets, one resident receiving dialysis treatments, two residents with pressure ulcers, and five residents on hospice care. Fourteen residents were dependent on staff for bathing, four residents were dependent on staff

for dressing, eight residents were dependent on staff for transferring, seven residents were dependent on staff for toilet use, and five residents were dependent on staff for eating.

During interview with V7 (DON) at 1:20 pm on

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET **BETHALTO CARE CENTER** BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **IEACH CORRECTIVE ACTION SHOULD BE** PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 9 S9999 7/22/2019, V7 stated that she was not aware of the facility closing until today (7/22/2019) at 10 a.m. V7 stated that she was in the process of notifying families. According to V7 (DON), "I have talked to ten families. I told them there was a possibility we might be closing. I told them there is a possibility that we might have to be discharging people this week. I told the families that we could help with the paperwork and any assistance they needed, but that they (residents and families) should start calling around to other facilities. Later I did notify the families again because V1 (Administrator) told me to put everything on hold because there might be a potential buyer." V7 (DON) stated that no other facilities or hospice had been notified to "transfer residents." At this time, V7 verified that five residents (R6, R25, R32, R38, R42) in the facility were hospice residents. V8 (Social Service Designee/Cook) stated at 2:30 pm on 7/24/2019 that "Monday (7/22/2019) is the first time I heard they were closing. V4 (CPC) ran the meeting. V4 said as soon as everyone was placed in another home, they (Bethalto) would be closing. I was told to call the paid activities and cancel them. Today (7/24/2019) I notified all the unpaid activities that we are closing so they (unpaid activities) would not show up." V1 (Administrator) stated on 7/23/2019 at 8:20 am "we are moving everyone to the North hall. We are closing. We will be totally closed in 30 days. I am telling families that the residents must be placed within 30 days as of yesterday. V4 (CPC) is calling families and I will be calling as soon as I can. All residents and families have been notified of the room changes. No kitchen staff showed up today including the Dietary Manager. Breakfast was put together by five

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **815 SOUTH PRAIRIE STREET** BETHALTO CARE CENTER BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 | Continued From page 10 S9999 staff, (Administrator, Director of Nursing, Maintenance Director, Social Service Designee/Cook, and Care Plan Coordinator.) We have not reached out to other homes yet because we have been busy. Telling families this is the utmost importance. To get them (residents) settled in new home before we are totally closed. In case the new home need help with them. We are encouraging them (residents/families) to call nursing homes to get them evaluated and accepted. We have enough food, plus there is a grocery store uptown." Surveyors and Ombudsmen onsite attended a meeting held at the facility on 7/23/2019 at approximately 10:30 am. At this meeting V1 (Administrator) told residents and families that they had three days to get moved out of the facility. V1 denied saying this when talking with V10 (Regional Supervisor) on 7/23/2019 at 10 pm. V1 (Administrator) stated at 12:05 pm on 7/23/2019 that "I think 3 days is honest to keep staff." We are doing everything we can to get placement. We have notified (4 Long Term Care Facilities listed by name.) They are all in the building now evaluating residents. We asked if they could come this week and they said they would be here today. We are calling families and I am recommending homes I believe are good, unless the family has a specific home request. V1 was asked regarding letters of notification of closure. V1 (Administrator) stated "Why would I send letters when they have been told this morning?" V2 (R2's Family Member) stated that R2's financial POA (power of attorney) had been called earlier that day, informing her that the facility was

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6000863 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET BETHALTO CARE CENTER BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 11 S9999 out of funds and had to close. V3 (R2's Financial Power of Attorney) was told that R2 had to move in 3 days. V2 stated that R2 was in tears over the move. According to V2, R2 would require a special medical assisted van for transport to Ohio-which would be R2's choice of new facility. V2 said it would be at least a week before arrangements could be made for this transfer. V2 continued that he had been in the nursing home business for 29 years as an Executive Director. V-2 stated that V1 (Administrator) should "have been smart enough to borrow funds before this happened." R2 stated on 7/24/2019 at 10:47 am that she had moved to a local facility until her family could arrange for her to move to Ohio later in September. Earlier in the day on 7/23/2019 at 8:30 am when asked about any transfer agreements with her emergency evacuation plan, V1 (Administrator) stated that her "transfer agreement is with (2 Hospitals listed by name.) I chose the hospital because it the safest place for them and they will always take them." Census information provided at 4:15 pm on 7/23/2019 indicated that 32 residents remained in the building. At 9:31 pm on 7/23/2019 V10 (Regional Supervisor) received a call from Regional **Emergency Preparedness Supervisor that** ambulances were being summoned to the facility. V10 arrived onsite at the facility at 10 pm. At the time of V10's arrival, only 14 residents remained in the facility-indicating that 18 residents were transferred from the facility between 4:15 pm and 10 pm. Between 5 pm when the surveyors left and 10 pm when V10 arrived on site, the remaining 18 residents were now all housed on

Illinois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_ COMPLETED C IL6000863 B. WING 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **815 SOUTH PRAIRIE STREET BETHALTO CARE CENTER** BETHALTO, IL 62010 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 12 S9999 the North wing. Observations by surveyors onsite confirmed that only 8 residents remained in the building as of 11:18 am on 7/24/2019, with the last resident being transferred from the facility at 2:25 pm on 7/24/2019. (A)